

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER The Greens at Hendersonville		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 Pisgah Drive Hendersonville, NC 28791	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272</p> <p>Based on observations, record review and interviews with staff the facility failed to provide a dependent and tall resident with a bed extender for (1 of 1) resident reviewed for accommodation of needs (Resident #256).</p> <p>Findings included:</p> <p>Resident #256 was admitted to the facility on [DATE].</p> <p>Resident #256 was admitted with diagnosis that included right side paralysis and healing from left fibula fracture.</p> <p>A review of his medical record revealed his height was 72 inches tall.</p> <p>The admission Minimal Data Set (MDS) dated [DATE] coded Resident #256 as cognitively intact. The MDS coded Resident #256 as needing maximum 2-person assistance with transfers, and dependent with bed mobility.</p> <p>Resident #256 was care planned for activities of daily living (ADL) self-care performance deficit and required staff assistance to complete ADL tasks daily (10/17/24). Interventions included the resident's usual performance is to roll left to right, sitting to lying, and lying to sitting (dependent).</p> <p>An in-room observation was conducted in Resident #256's room on 10/29/24 at 10:50 AM. Resident #256 was observed laying in his bed with the head of the bed elevated. His body was positioned diagonally with his head and upper body on the resident's upper right corner of the bed and both his feet pressed against the left side of his bed's foot board.</p> <p>Further in room observation on 10/31/24 at 2:12 PM found Resident #256's feet pressed against the bed foot board.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #256 stated in an interview on 10/29/24 at 10:53 AM that he was too long for his bed and his feet were pushed against the foot board when he elevated the top of his bed. He stated it was hard for him to reposition up in his bed to keep his feet from touching the foot board. Additionally, he stated he was able to shift his body diagonally in his bed and it was more comfortable for him and his feet would not be pressed against the foot board. Resident#256 stated a few days after he had moved into his room, he told a staff he was too long for his bed, and he had not been placed in a longer bed and his feet had been pressed against the foot board since he was admitted . He was unable to recall who he had told he was too long for his bed. Resident #256 stated he was paralyzed on his right side of the body and could not reposition easily to prevent his feet from touching the foot board.</p> <p>The Physical Therapist (PT) was interviewed on 10/31/24 at 9:13 AM. The PT stated Resident #256 was receiving PT to work on safety awareness to operate in his home. His goals included to do stand and pivot transfers. Resident #256 had halo bed rails placed on his bed to help with repositioning in bed on 10/17/24. The PT stated Resident #256's body did shimmy down his bed when the head of bed is elevating causing his feet to touch the foot board. The PT said the maintenance department would install bed extenders on beds and he was unaware if maintenance had been notified about the bed extender.</p> <p>Resident #256's Occupational Therapist Assistant (COTA) was interviewed on 10/31/24 at 9:44 AM. She stated Resident #256 was working on strengthening his core and balance for upper body strength so he could pull himself up in bed. She stated Resident #256 would benefit from an extended bed to keep his feet from touching the footboard. The COTA said Resident #256 had made comments to her that he felt really long in his bed, and she had seen his feet touching the foot board. She said Resident #256 did slide down in his bed when the head of the bed was elevated, and she would help the resident slide his body back to the top of the bed.</p> <p>Resident #256's assigned Nursing Assistant (NA) #1 was interviewed on 10/31/24 at 11:56 AM. She stated she had been assigned to Resident #256 when she worked from 7:00 AM to 7:00 PM. NA #1 stated she had seen that his feet would be pushed against his bed's foot board in the morning when she went into his room to check on him after starting her shift at 7:00 AM. NA #1stated Resident #256 had not complained to her about his feet touching the foot board. Resident #256 had told her he shifted his body diagonally in the bed to give his feet more room without touching the foot board. NA #1 said she would help reposition the resident in bed to make him more comfortable by sliding him up to the top of his bed. NA #1 stated she did not know a bed extender could be used to lengthen Resident #256's bed and had not told the nurse about Resident #256's feet touching the foot board.</p> <p>The Maintenance Director was interviewed on 10/31/24 at 1:58 PM and stated he did install bed extenders on two beds and had not been notified Resident #256 needed a bed extender. He stated the nurses would normally let him know if a resident needed an extended bed and that he did have extenders available in the facility.</p> <p>The Director of Nursing (DON) was interviewed on 11/1/24 at 2:25 PM. She stated Resident #256 was tall and did need a bed extender to prevent his feet from pressing against his foot board. The DON stated the resident's assigned NAs and Nurses needed to notify the Maintenance Director for a bed extender when identified.</p> <p>(continued on next page)</p>		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 11/1/24 at 3:33 PM. She stated Resident #256's need for a bed extender should have been reported so it could have been addressed.		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014</p> <p>Based on observations, record review and staff interviews, the facility failed to ensure the armrest of Resident #75's wheelchair remained in good repair for 1 of 3 wheelchairs observed for safe, clean and homelike environment.</p> <p>Findings included:</p> <p>Resident #75 was admitted to the facility on [DATE].</p> <p>The significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #75 had severe cognitive impairment.</p> <p>During an observation on 10/29/24 at 12:28 PM Resident #75 was sitting up in his wheelchair in his room eating lunch. On the left side of Resident #75's wheelchair, the padded armrest was being held in place to the armrest frame by 4 rows of purple tape that were wrapped around the bar of the armrest frame and top of the padded armrest. The material of the padded armrest was not cracked, broken or frayed.</p> <p>Subsequent observations conducted on 10/30/24 at 8:55 AM and 10/31/24 at 1:45PM revealed the condition of the armrest on Resident #75's wheelchair remained unchanged.</p> <p>During an interview on 10/31/24 at 1:49 PM, Nurse Aide (NA) #4 revealed Resident #75 usually sat up in his wheelchair when eating his meals. NA #4 stated when she noticed a wheelchair needing repair, she notified the Unit Manager or Nurse Supervisor who then notified the Maintenance Director. NA #4 confirmed the left armrest on Resident #75's wheelchair had purple tape wrapped around the wheelchair frame holding it into place. NA #4 stated she had not previously noticed the condition of the armrest on Resident #75's wheelchair and had not notified anyone that it needed repair.</p> <p>An observation of Resident #75's wheelchair and subsequent interview was conducted with the Maintenance Director on 10/31/24 at 1:57 PM. The Maintenance Director explained he replaced armrests on wheelchairs when informed by staff that repairs were needed but stated he had not been notified that the armrest on Resident #75's wheelchair needed to be replaced. The Maintenance Director confirmed the left armrest of Resident #75's wheelchair had 4 rows of purple tape wrapped around the wheelchair frame holding it into place and stated it was something that he should have been made aware of for repair to be made.</p> <p>During an interview on 10/31/24 at 2:15 PM, the Nurse Supervisor revealed staff usually let her know when repairs were needed and she informed the Maintenance Director. The Nurse Supervisor stated no one had mentioned anything to her regarding the armrest on Resident #75's wheelchair needing repaired.</p> <p>During an interview on 11/01/24 at 2:41 PM, the Director of Nursing (DON) stated staff should have notified the Maintenance Director when Resident #75's wheelchair armrest was noticed needing repair.</p> <p>(continued on next page)</p>		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/24 at 3:42 PM, the Administrator stated she would have expected for staff to have notified the Maintenance Director that the armrest of Resident #75's wheelchair needed repair so that it could have been fixed sooner.		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538</p> <p>Based on record review, observations, and interviews with the staff the facility failed to ensure the air mattress settings matched the resident's current weight for 2 of 3 residents reviewed for pressure ulcers (Resident #41 and #37).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #41 was admitted to the facility on [DATE] with diagnoses including age-related physical debility and Parkinson's disease. <p>The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #41 needed supervision/touching assistance to roll in bed and move from a sitting to lying position with no unhealed pressure ulcers or other skin conditions. The MDS noted a pressure reducing device was used for the bed.</p> <p>The care plan revised on 09/23/24 revealed Resident #41 was admitted to the facility with an unstageable pressure ulcer on the right buttocks that previously resolved but reopened on 09/23/24. Interventions included to monitor air mattress settings to ensure they were set to the resident's weight.</p> <p>The current physician orders included the use of an air mattress with directions to monitor the settings every shift and set to the resident's weight started on 09/23/24.</p> <p>A review of Resident #41's Medication Administration Record (MAR) for October 2024 included the physician order for an air mattress with directions to check the settings and set at the resident's weight. The checks were scheduled every shift from 7:00 AM through 7:00 PM and 7:00 PM through 7:00 AM and initialed by the nurses to indicate they checked the air mattress and the weight setting was correct from 10/01/24 through 10/31/24.</p> <p>A review of Resident #41's most current weight documented on 10/17/24 was 148.4 pounds.</p> <p>An observation on 10/31/24 at 10:28 AM revealed Resident #41 resting in the bed on the air mattress. The air mattress setting for weight was set at approximately 182 pounds.</p> <p>During an observation and interview on 11/01/24 at 11:32 AM Nurse #2 confirmed she was the assigned nurse for Resident #41 on 10/31/24 from 7:00 AM through 7:00 PM. Nurse #2 observed the air mattress weight setting was approximately 182 pounds and revealed when she initialed the MAR she checked the air mattress pump to ensure it was functioning. Nurse #2 stated she did not check the weight settings on the air mattress to ensure it was correct based on the weight of Resident #41 and she did not change the weight settings on the air mattress.</p> <p>An interview was conducted on 11/01/24 at 11:33 AM with the Director of Nursing (DON). The DON stated the nurses should visually check the weight setting on the air mattress to ensure it was correct based on the resident's current weight. The DON adjusted the weight setting to Resident #41's current weight of 148.4 pounds.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #37 was admitted to the facility on [DATE]. Resident #37's diagnoses included dementia and malnutrition.</p> <p>A review of the current physician orders included the use of an air mattress with directions to ensure the setting matched Resident 37's current weight started on 06/19/24.</p> <p>The care plan revised on 08/05/24 identified Resident #37 as having the potential for developing a pressure ulcer related to needing assistance with bed mobility and refusal to wear and at times removed heel protector boots. Interventions included the use of an air mattress and ensure settings matched the current weight of the resident.</p> <p>Resident #37's quarterly MDS assessment dated [DATE] indicated there were no unhealed pressure ulcers or other skin issues and a pressure reducing device was used for the bed.</p> <p>A review of Resident #37's most current weight documented on 10/18/24 was 95.5 pounds.</p> <p>A review of Resident #37's MAR for October 2024 included the physician order with directions to check the air mattress to ensure the setting matched the resident's current weight. The checks were scheduled every shift from 7:00 AM through 7:00 PM and 7:00 PM through 7:00 AM and initialed by the nurses to indicate they checked the air mattress and the weight setting was correct from 10/01/24 through 10/31/24.</p> <p>The weekly skin assessment date 10/28/24 revealed Resident #37 had no new skin abnormalities.</p> <p>Observations on 10/29/24 at 3:02 PM and 10/30/24 at 3:51 PM revealed Resident #37 resting in bed on the air mattress. The weight setting on the air mattress was set at approximately 252 pounds.</p> <p>During an interview and observation on 11/01/24 at 11:18 AM Nurse #1 confirmed she was the assigned nurse for Resident #37 on 10/29/24 and 10/30/24 from 7:00 AM through 7:00 PM. Nurse #1 observed the weight setting on the air mattress was approximately 252 pounds and stated that was incorrect and she knew Resident #37 did not weigh that much.</p> <p>An interview and observation was conducted on 11/01/24 at 11:23 AM with the Director of Nursing (DON) in the presence of Nurse #1. The DON observed the weight setting on the air mattress was approximately 252 pounds and stated Resident #37's current weight was 95 pounds. It was shared with the DON the weight setting was observed at 252 pounds on 10/29/24 and 10/30/24 and had not changed. The DON stated when the nurses initialed the MAR they should visually check the weight setting on the air mattress and ensure it was correct based on the resident's current weight. The DON changed the weight setting on the air mattress to match Resident #37's current weight.</p> <p>An interview conducted on 11/01/24 at 3:45 PM with the Administrator revealed when the nurses initialed the MAR for air mattress settings it was expected they visually checked the setting to ensure it was correct based on the resident's current weight.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272</p> <p>Based on record review and staff, Consultant Pharmacist and Nurse Practitioner (NP) interviews the facility failed to follow up on a consultant pharmacist recommended Gradual Dose Reduction attempt (GDR) for a resident. This was for 1 of 5 residents reviewed for unnecessary medications (Resident #13).</p> <p>Findings Included:</p> <p>Resident #13 was admitted on [DATE] with diagnosis that included dementia and diabetes mellitus.</p> <p>A review of Resident #13's quarterly Minimal Dat Set (MDS) dated [DATE] coded her with severe cognitive impairment. She required supervision for eating and toileting, used a wheelchair for mobility and frequently incontinent of bowel and bladder. She was coded as receiving an antidepressant during the 7-day look back period.</p> <p>A review of the pharmacy recommendations dated 7/24/24 for Resident #13 indicated a Gradual Dose Reduction attempt (GDR) was recommended by the Consultant Pharmacist. The Nurse Practitioner (NP) agreed to the GDR for Trazadone 50 mg to Trazadone 25 mg once daily at hours of sleep (HS) and was signed on 9/10/24. The pharmacy recommendations for October 2024, recommended a GDR for Trazadone 50 mg to Trazadone 25 mg once daily at HS. The NP agreed to the GDR and signed the order on 10/19/24.</p> <p>A review of Resident #13's physician orders for September 2024 found that no order for Trazadone 25 mg had been entered on 9/10/24 or after that date.</p> <p>A review of Resident #13's physician orders for October 2024 found that Trazadone 50 mg was discontinued on 10/21/24. A physician's orders for Trazadone 25 mg once daily at HS was entered on 10/21/24.</p> <p>A review of Resident #13's Medication Administration Record (MAR) for September 2024 found that the resident received Trazadone 50 mg once daily during HS every day after the signed order on 9/10/24.</p> <p>A review of Resident #13's October 2024 MAR found the resident received Trazadone 50 mg daily during HS every day until 10/21/24. The MAR indicated that Trazadone 25 mg daily during HS was received by the resident beginning on 10/21/24.</p> <p>The Consultant Pharmacist was interviewed via phone on 11/1/24 at 9:50 AM. She stated she recommended GDR for Resident #13 in her pharmacy review conducted on 7/24/24. The Consultant Pharmacist stated a facility has 30 days to respond to her recommendations. In her September pharmacy review for Resident #13, the GDR for Trazadone had not been attempted, and the GDR recommendation was given to the facility again. The Consultant Pharmacist indicated she was unaware why the recommendation signed on 9/10/24 was not completed for Resident #13. She stated her monthly pharmacy recommendations are given to the Director of Nursing who provides them to the providers.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The NP was interviewed via phone on 11/1/24 at 10:16 AM. The NP stated she had been a provider at the facility beginning in early September 2024. She stated there were multiple pharmacy recommendations provided to her from the DON when she began working at the facility. The NP indicated she was not aware the order for the GDR was not entered for Resident #13 after it had been signed on 9/10/24. The NP stated the October 2024 pharmacy review asked for a GDR for the medication again, and again agreed to the GDR of Trazadone on 10/19/24. The NP stated her orders for the GDR should have been entered by the unit manager or DON.</p> <p>The Unit Manager was interviewed on 11/1/24 at 3:43 PM. She stated the providers did give her the pharmacy recommendations after they had been signed by the provider. The Unit Manager said it was her responsibility to ensure all pharmacy recommendations and orders had been entered into resident charts. The Unit Manager stated she always signed and dated each pharmacy recommendation after it was entered into each resident's chart. The pharmacy recommendation for Resident #13 signed by the Nurse Practitioner on 9/10/24 for a gradual dose reduction attempt of Trazadone 50 mg reduced to 25 mg by mouth at hours of sleep (HS) was reviewed by the Unit Manager and was not signed by her to indicate the order had been entered. The Unit Manager stated she overlooked the pharmacy recommendation, and did not enter the order for the GDR.</p> <p>The Director of Nursing (DON) was interviewed on 11/1/24 at 2:25 PM. She stated the facility had changed providers in September 2024 and there had been some confusion on which pharmacy recommendations the previous providers agreed with at that time. The signed order for GDR should have been entered into Resident #13's chart when it was signed by the NP on 9/10/24.</p> <p>The Administrator was interviewed on 11/1/24 at 3:33 PM. She stated the Unit Manager overlooked the order for the GDR and the order should have been entered for Resident #13.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272</p> <p>Based on observations and staff interviews the facility failed to store a staff member's opened drink bottle separate from residents' stored food in 1 of 3 kitchen refrigerators. The facility failed to maintain and clean 1 of 1 milk cooler, 1 of 2 ice machines, and 1 of 1 floor kitchen drains, and 1 of 1 baking sheet storage rack. The facility failed to date an opened nutritional supplement in 1 of 1 nourishment refrigerators. This practice had the potential to affect one-hundred and five (105) residents who resided at the facility.</p> <p>Findings Included</p> <p>1. On [DATE] at 9:13 AM an observation of the reach-in milk cooler was found with an opened soda bottle laying on top of stored milk cartons.</p> <p>The morning cook stated on [DATE] at 9:15 AM the opened soda bottle belonged to kitchen staff, and she was unsure which staff it belonged to. She stated the drink bottle should not be kept in the cooler.</p> <p>2. On [DATE] at 9:13 AM an observation of the reach-in milk cooler revealed the bottom of the milk cooler contained baking sheets which were covered with parchment paper. Multiple areas of parchment paper on each baking sheet contained dried white substance with a fuzzy greenish to brownish substance.</p> <p>3. An observation of the inside of the kitchen ice maker on [DATE] at 9:17 AM found the white plastic ice shield to be unclean. The bottom of the plastic shield was directly touching the ice in the machine and the plastic shield contained an orange/pink substance that spanned the length of the ice shield.</p> <p>On [DATE] a follow-up kitchen observation was made with the District Dietary Manager. The ice machine plastic shield remained unchanged at 11:38 AM on [DATE].</p> <p>4. At 11:40 AM on [DATE] the in-floor drain cover for the two-compartment sink was observed to contain a thick layer of slimy white and pinkish/red colored substance covering a large portion of the drain cover.</p> <p>5. At 12:33 PM on [DATE], the observation found the storage rack for ready-to-use baking sheets to contain a thick buildup of yellow and waxy to touch substance directly under the baking sheets.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The District Dietary Manager stated on [DATE] at 3:34 PM she had been the temporary Dietary Manager for the kitchen since the end of [DATE]. She stated the previous Dietary Manager did not use a cleaning sheet for the kitchen staff to sign off what had been cleaned and she had started a daily cleaning sheet with assignments for kitchen staff. The District Dietary Manager said kitchen staff should not store personal food items in resident areas, the kitchen staff have their own refrigerator for personal items. She said the ice machine was cleaned monthly by the maintenance department and maintenance would clean it in between when notified. Additionally, the District Dietary Manager stated the reach-in milk cooler would be cleaned monthly or when needed. The clean storage racks, the floor drains and reach in cooler were not on a cleaning list and were assigned to be cleaned on weekends and should have been cleaned.</p> <p>6. The nourishment room refrigerator was observed on [DATE] at 4:02 PM with the District Dietary Manager. The refrigerator door contained one small carton of nutritional supplement that was opened without an open date on it. The District Dietary Manager stated during the observation that the nutritional supplement was placed by a nurse without an open date after the refrigerator had been checked for opened and expired items earlier that day.</p> <p>The Maintenance Director was interviewed on [DATE] at 3:20 PM. He stated he cleaned the ice machine in the kitchen and nourishment room once monthly regularly and when needed. He stated he was not aware the kitchen ice machine needed to be cleaned, normally a kitchen staff would let him know or place it on the maintenance log.</p> <p>The Administrator stated on [DATE] at 3:30 PM dirty areas of the kitchen should be cleaned regularly and when dirty. She said the items in the nourishment room refrigerator should be dated when opened and disposed of when it expired.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER The Greens at Hendersonville		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 Pisgah Drive Hendersonville, NC 28791	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37014</p> <p>Based on observations, record review, and interviews with staff, the facility failed to follow their infection control policy and procedures regarding Enhanced Barrier Precautions (EBP) during high-contact care activities for a resident with an indwelling catheter (Resident #75). This failure occurred for 2 of 2 nursing staff observed for infection control practices (Nurse Aide #2 and Nurse Aide #3).</p> <p>Findings included:</p> <p>Review of the facility's Enhanced Barrier Precautions (EBP) policy and procedures dated 04/24/24 read in part, EBP are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (abbreviated as MDRO and refers to a type of bacteria that are resistant to one or more classes of antibiotics) to residents. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact care activities requiring the use of gown and gloves for EBP include transferring, changing briefs or assisting with toileting and medical device care or use such as urinary catheter. The policy noted EBP should be used until the discontinuation of the indwelling medical device that placed the resident at higher risk.</p> <p>A physician's order dated 05/06/24 revealed in part Resident #75 was on EBP due to an indwelling urinary catheter and history of methicillin-resistant staphylococcus aureus (abbreviated as MRSA and refers to a type of bacteria resistant to several antibiotics).</p> <p>a. During an observation on 10/29/24 at 11:58 AM, Resident #75 was observed lying on a low bed stating he needed to use the bathroom. EBP signage was posted on the door of Resident #75's room instructing staff to wear a gown and gloves for high-contact resident care activities that included transferring, providing hygiene, changing briefs or assisting with toileting. A cart containing Personal Protective Equipment (PPE) that included gowns, gloves and masks was positioned just outside the door. Nurse Aide (NA) #2 and NA #3 were observed sanitizing their hands and donning gloves prior to entering Resident #75's room and closing the door. At 11:59 AM, when opening the door to Resident #75's room, NA #2 and NA #3 were observed holding on to Resident #75's hands/arms and physically assisting him up out of bed and into his wheelchair. Neither NA #2 nor NA #3 had donned a gown prior to assisting Resident #75 with transferring.</p> <p>During an interview on 10/29/24 at 12:02 AM, NA #3 exited Resident #75's room and walked to the linen cart located in the hall to gather supplies. NA #3 voiced knowledge of EBP but stated she had not noticed the EBP sign posted on Resident #75's door. NA #3 confirmed she had assisted NA #2 with transferring Resident #75 up out of bed and did not don a gown as instructed on the EBP signage prior to performing high-contact resident care. NA #3 stated she was only trying to help and should have donned a gown in addition to gloves.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Greens at Hendersonville		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 Pisgah Drive Hendersonville, NC 28791	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During an observation and interview on 10/29/24 at 12:04 PM, upon knocking on and opening the door of Resident #75's room, Resident #75 was in the bathroom and NA #2 was observed standing by the bathroom door unfolding a brief. NA #2 was not wearing a gown. NA #2 looked into the bathroom and told Resident #75 she would be right back and then walked toward the bedroom door. NA #2 confirmed the EBP signage was posted on Resident #75's door and stated that she was unaware Resident #75 was still on EBP. NA #2 stated Resident #75 was on the toilet and she was assisting him with care. NA #2 verified she did not don a gown prior to assisting Resident #75 up out of bed and to the bathroom. NA #2 expressed she always wore gloves when providing high-contact resident care activities and should have also donned a gown according to the EBP signage.</p> <p>During an interview on 11/01/24 at 9:33 AM, the Director of Nursing (DON)/Infection Preventionist confirmed Resident #75 was on EBP due to having an indwelling urinary catheter. The DON explained if nursing staff were only providing verbal cueing to residents on EBP, then a gown was not necessary. However, if staff were actually touching the resident and/or providing physical assistance during high-contact resident care, they were expected to don the appropriate PPE.</p> <p>During an interview on 11/01/24 at 3:42 PM, the Administrator stated staff had received education related to EBP and the posted signage was pretty clear as to what nursing staff were required to do. The Administrator stated both NA #2 and NA #3 should have followed the EBP instructions regarding PPE use when providing Resident #75's care.</p>		